



The Office of the
Committee for
Health & Social Care

**REGISTRATION AND INSPECTION
OF
PRIVATE NURSING AND RESIDENTIAL HOMES**

Les Bourgs Hospice

INSPECTION REPORT

DATE: 17/07/19

This report may only be quoted in its entirety and may not be quoted in part or in any abridged form for any public or statutory purpose

HEALTH & SOCIAL CARE
REGISTRATION AND INSPECTION OF
PRIVATE NURSING AND RESIDENTIAL HOMES

INTRODUCTION

The Registration and Inspection unit of Health & Social Care has a statutory responsibility to inspect private nursing and residential homes within the Bailiwick of Guernsey at least twice per year. The Registration and Inspection officer undertakes a minimum of one announced and one unannounced inspection per year.

The inspections are undertaken in order to establish whether the care home is meeting the legal requirements i.e. The Nursing and Residential Homes (Guernsey) Law 1976 and its associated Ordinances, together with the agreed standards.

In reading the report, the following factors should be borne in mind:

- The report is only accurate for the period when the home was inspected.
- Alterations to physical facilities or care practices may subsequently have occurred in the home.
- Feedback will have been given orally to the senior person on duty at the time of the visit.
- Both the Inspector and the Registered Home Owner/Care Manager of the home to which it refers will agree the report as an accurate report.
- The report will show the compliance with the Regulations and standards and the required actions on behalf of the provider.

Name of establishment: **Les Bourgs Hospice**

Address: **Andrew Mitchell House, Rue de Tertre, St Andrews, GY6 8SF**

Name of registered provider: **Les Bourgs Hospice Charitable Trust**

Name of registered manager: **Mrs J Boyd MBE (Hospice Director)**

CATEGORIES/NUMBER OF REGISTERED BEDS

CATEGORY	NUMBER REGISTERED
Nursing	7

Date of last inspection visit: 27/09/18 - Announced
Date of inspection upon which this report is based: 17/07/19
Category of inspection: Announced
Vanessa Penney Registration and Inspection Officer

The Inspection findings relate to the Projet de Loi and its associated Ordinances. These are supported by the agreed Guernsey Standards for Care Homes as examples of 'Best Practice' and it is against these that form the basis of the inspection and its findings. The report follows the format of the Guernsey Standards and the numbering shown in the report corresponds to that of the Standards.

INSPECTION REPORT

Identified below are areas addressed in the main body of the report, which are seen as health and safety, and/or good practice issues which the Registered Provider should consider for implementation.

RECOMMENDED PRACTICE DEVELOPMENTS	Refer to standard
There were no areas of concern noted on this visit. The team continue to work on quality assurance initiatives to ensure the person and their family receive the best possible service in hospice care	

STANDARD 1: INFORMATION

OUTCOME: The intended outcomes for the following set of standards are:

- **Service users have the information they need to make an informed choice about where to live.**
- **Each service user has a guide to the facilities.**
- **Each service user has a written contract/statement of purpose setting out the aims and objectives of the home.**
- **Each service user understands how to contact the Health Services Inspector and other local health and social services.**

Key findings/Evidence:

Les Bourg's Hospice is a registered charity providing specialist care for people with a life limiting illness. The hospice is purpose built and is registered for 7 beds. On the day of the inspection there were 6 in-patients. As well as the in-patient service it also offers a weekly day hospice service. These 2 services provide support and care for people needing help with complex symptom management, pain management and with end of life care.

In order to provide people with information regarding the care and services that are offered at the hospice, there is an informative website at www.lesbourgshospice.org.gg and a colourful brochure is available to download. The website information includes the following: philosophy of care, an explanation of the types of care provided; in-patient care, respite care and day hospice service. There is also a description of the accommodation with photographs of the en-suite rooms, various communal rooms and of the gardens. The website has been updated to also include information for data protection.

The information includes the Directors of the Board and also provides an overview of the care team and volunteers. The information discusses that the hospice is an independent charity therefore there is no fee to be paid for a stay at the hospice; however, visits required by a person's GP must be funded by the person as they would do if the GP was making a visit to a person's own home.

When a person is admitted to the hospice 2 booklets are available in each room; 1 for the patient and 1 for the person's next of kin (NOK) (booklet also available to download online) and the information can also be provided in large print to aid a person with visual impairment. A feedback sheet is included in the booklet, which the Hospice Director retains to action, for the ongoing development of the care and services at the hospice. The booklet is updated using the feedback received from in-patients, day service users and their relatives and the staff.

Following an inspection the hospice director retains a copy of the report for patients, relatives, staff and visitors to the hospice to read (front desk, office for staff).

STANDARD 2: CONTRACT
OUTCOME: Each service user has a written contract/statement of terms and conditions with the home.
Key findings/Evidence:
<p>This standard is not applicable, as people are not issued with a contract. They are not admitted for long term care or billed for services provided by the team at the hospice.</p> <p>During the admission process, the patient and/or their family are provided with much of the information that would normally be provided within a formal contract. This includes the services provided, length of stay and services that require payment by the patient e.g. GP visits. The policies for visiting, therapies, smoking and laundry arrangements are discussed and also the safekeeping of money and valuables.</p>

STANDARD 3: NEEDS ASSESSMENT
OUTCOME: No service user moves into a home without having had his/her needs assessed and been assured that these will be met.
Key Findings/Evidence:
<p>The hospice is a charitable trust and does not receive care grants from Employment & Social Security or funding from the States of Guernsey. The Needs Assessment Panel from within Health & Social Care (HSC) do not assess the people who are admitted to the hospice prior to admission. Admissions are generally organised through a person's GP and from the Community Nurses/Palliative Care Team.</p> <p>The Hospice Director, Ward Manager or Ward Sister attend a 'Gold Standard Framework' meeting which other members of the multi-professional team also attend e.g. GPs, Palliative Care Team etc. On a Friday the Hospice Director, Ward Manager or the Ward Sister attend multidisciplinary meetings with Social Workers, Palliative Care Specialist Nurses, Oncology Consultant and with the Registered General Nurses (RGNs) at Bulstrode House. These meetings are invaluable as they enable the team to be aware of new clients who may require their services either immediately, or in the near future and enable the team to plan for a complex admission prior to a person being admitted to the hospice and also for ongoing care. This also supports the team with organising co-ordinated and planned discharges.</p> <p>The criteria for admission accessibility to the hospice service is:</p> <ul style="list-style-type: none"> • Any person who has a life limiting disease/illness. • In-patients are not able to stay in the hospice long-term. They must be prepared to return home with the support of the Palliative Care Specialist Nurses and the Community Nursing Services, or to move into a nursing home once pain management and symptom control etc have been established.

- The person must be 18 years or over.

The Hospice Director or her deputy will always assess the needs of a person prior to a person being admitted and will visit the person at home or in hospital if the person is not already known to them (through day hospice or respite care). If the Palliative Care Nurses are already providing care for the person at home and the person is being admitted into the hospice, the RGNs at the hospice rely on the palliative team's assessment. This is excellent as it demonstrates an effective working relationship and communication between the Palliative Care Specialist Nurses and the team at the hospice. Additionally, it saves the patient/relative having to duplicate information.

As the hospice has only 7 beds, admissions are prioritised if there is a lack of beds for the number of people requiring access to the service. Each referral received, is assessed by the RGNs to enable them to make a decision on which admission takes priority. An updated hospice referral form assists the hospice staff with prioritising admissions and aid health professionals making the referral in assessing what the patient needs to be admitted for i.e. respite/symptom management or EOLC. The form has a section where, Symptom Severity Score and Karnofsky performance scale, is available for the health professional completing the referral and for hospice staff to utilise.

On admission to the hospice the person has a more comprehensive assessment, which informs the care plan. The model used is a more detailed version of the Roper et al model - assessing activities of daily living, which ensures that the identified needs are met and provides guidance to monitor individual outcomes and to establish the level of support each person requires. Core care plans are also included where needed. Previous audit of the admission and discharge information led to the documentation being reviewed and updated to ensure that all of the necessary information is captured. These audits are on-going for quality assurance and further development where needed.

Specific accredited tools such as pain assessment and tissue viability scoring are used as appropriate to help inform the care to be delivered and its evaluation for the specific needs of the individual patient. In the event that this cannot be done in-house, support is requested from other allied healthcare practitioners, for example the Speech and Language Therapist to assess swallowing.

During the assessment process patients and relatives wishes for care involvement are identified, discussed and are reviewed periodically, which is important and demonstrates that there is involvement in care planning and care delivery.

Following their stay at the hospice, the person is discharged either back into the community or possibly into a nursing home and therefore there is a lot of preparation undertaken for discharge planning e.g. organising further services such as the Community Nurses, Meals on Wheels or for informing the relevant relatives/people that the patient has returned home e.g. the patient's NOK and GP. Although discharge is not part of the standards, this is crucial for ensuring continuity and quality of on-going care and treatments.

The admission documentation also reflects the patient's home circumstances in preparation for successful discharge; recording whether the patient lives alone, family dynamics, whether their

home has stairs, who will do the shopping and cleaning, and whether the person has a life-line etc.

Within 48 hours of discharge the person's bed is held (for complex cases); if the discharge is not successful the person can then be re-admitted. This is excellent and provides the person and family with a 'safety net' if things do not go as expected. After the 48-hour period has elapsed, the person and/or family are contacted to ensure that they are coping and then the person is formally discharged. This demonstrates an excellent system of communication and with understanding both the needs of the person and their family/carer.

STANDARD 4: MEETING NEEDS

OUTCOME: Service users and their representatives know that the home they enter will meet their needs.

Key findings/Evidence:

The hospice provides care for people who have a life limiting disease/illness, which includes people with Cancer and also those with other non-malignant diseases such as Multiple Sclerosis, Motor Neurone Disease, Chronic Obstructive Pulmonary Disease and for end stage cardiac, renal and diabetes management.

The RGNs and the Health Care Assistants (HCAs) are encouraged to build upon their current level of knowledge and skills and to keep up to date through various resources - the hospice subscribes to journals that are relevant to their client group. The HCAs are supported to undertake the NVQ/VQ awards for ongoing training and development. If a HCA has no formal qualification when the person commences employment at the hospice, the care certificate forms part of the person's induction programme, which the person completes over a 6-month period.

The RGNs are supported to undertake courses for palliative care and the management of medication, which is frequently used with their client group; with several undertaking their studies to degree or masters level. All care staff have access to the internet where they are also able to undertake online training sessions. There is a resource file which all staff have access to. This file provides information for care, treatments and illnesses that the patients at the hospice will require support with. The resource file is kept up-to-date by the RGNs.

All of the staff have attended mandatory training such as first aid, anaphylaxis and CPR, infection control and food hygiene, which are delivered by an accredited trainer and several staff have attended training at specialist hospice centres in the UK. Moving and handling practice is provided all year around for all staff by the ErgoCoaches in the hospice (theory & practice). In addition, the RGNs attend training delivered by accredited trainers covering issues such as acute and chronic pain management and swallowing issues. The hospice has also taken advantage of belonging to an established link system with the specialist nurses from within HSC such as tissue viability, continence management, infection control, health & safety and respiratory problems. This facilitates good practice and demonstrates the hospice's commitment to enabling staff to keep up-

to-date with the latest developments. Individual link roles are kept up to date by the lead person for that link role; audits undertaken by the links are reported back to the Clinical Governance Team during meetings.

The hospice also belongs to the nurses' forum with the RGNs from the private care sector, where they have quarterly meetings to discuss relevant issues, offer support to one another and share training sessions. The team at the hospice offer training sessions for palliative care and an update for the use of a syringe driver and medication which is used for palliative care, with RGNs from the private nursing homes, which is an excellent initiative (ongoing).

STANDARD 5: TRIAL VISITS

OUTCOME: Prospective service users and their relatives and friends have an opportunity to visit and assess the quality, facilities and suitability of the home.

Key findings/Evidence:

The Hospice Director or her deputy in her absence, would accept an emergency admission if needed. However, if unknown to the team, an assessment will be undertaken prior to acceptance. This is to ensure the team will be able to manage a person's care needs, has or can obtain the necessary equipment required prior to admission and also the relevant healthcare professionals can be involved. Consideration is also given to the staffing level and the complexity of the current in-patients. Generally, there is time for a person and/or their relatives to view the hospice before accepting a bed. Respite referrals are received from GPs, Palliative Care Team; Palliative Care Social Worker, Community Nurses and at times family members contact the hospice directly. Patients also have an opportunity to attend day hospice during their admission.

A trial can be organised for day hospice care as this service is available every Thursday. Periodically when the need arises, a day hospice service is also offered on a Wednesday when there have been too many people for the one day per week. On this visit, there was no day hospice.

STANDARD 6: INTERMEDIATE CARE

OUTCOME: Service users assessed and referred solely for intermediate care are helped to maximise their independence and return home.

Key findings/Evidence:

The hospice offers 1 respite bed that can be booked in advance for complex respite. If the bed has not been booked, the bed will be occupied for an in-patient if needed at that time. Respite care is offered where the person's carer requires a break from providing/supporting the care package at home (more specialist care respite). The hospice team would endeavour to maintain current functional abilities (as appropriate) and to promote a social environment during the time the person is spending in the hospice. As discussed above in this report, before a person is discharged

back home, discharge-planning meetings are held with a person's NOK and the Community Occupational Therapist (if required), Community Nurses, Palliative Care Team and Palliative Care Social Worker. This is to undertake an assessment to see if equipment is needed, or to organise the required care package, before a person returns home.

Although the hospice has limited specialised facilities for promoting programmes of rehabilitation and in many cases this would not be appropriate; the Community Occupational Therapists will visit the hospice to support the staff and offer guidance through training sessions as required.

STANDARD 7: SERVICE USER PLAN

OUTCOME: The service user's health and social care needs are set out in an individual plan of care.

Key findings/Evidence:

When a person is admitted in to the hospice, an assessment is undertaken and from this, a plan of care is developed. The assessment includes mobility, tissue viability, pain management, nutritional needs and anxiety levels etc. Although care plans are person-centred, core care plans for some aspects of care are included. These include care for shortness of breath, terminal agitation, pressure area care (skin bundle), nausea and vomiting and catheter pathway. Additional care plans for a significant conversation with a patient or their NOK can also be added and also for opioid range for the management of chronic pain. There is also a core care plan for chemotherapy as well as additional specialised care plans for other treatments or conditions. The core care plans identify the author and the date of development. At the front of each care plan a signature list of all of the RGNs and HCAs, as well as any other health professionals who write in the care record is recorded.

An index page is at the front of each care plan, which assists with the navigation of individual elements of care and support within the care plan. All care plans are in a written format and are reviewed and are updated at a minimum of every 3 days; for respite care patients this might be undertaken within a slightly longer period if the person's condition is stable. Generally, updates are carried out more frequently as care needs and treatment changes and therefore, sometimes a care plan is reviewed and changes are made from shift to shift. A resident's care level is identified using a colour code system so that all staff are aware of the level of care and monitoring that each person requires. This is linked to the Gold Standard Framework colour coding that is also used in the Gold Standard Framework meetings with all the GP surgeries.

On admission, a person is also provided with a booklet titled 'Planning Ahead'. This gives a person the opportunity to let their family, friends and professionals know what is important to them for a time in the future where they may be unable to do so e.g. religious beliefs and choice in care and treatments etc.

The RGNs have also implemented a consent form, which they use to inform the decision for the use of equipment e.g. bed rails or heat pads for pain relief etc. or for treatments e.g. alternative or

complimentary therapies etc. The form has a risk assessment on the front and there is signed consent on the reverse of the form. This is excellent practice and demonstrates that the patient and/or their relative have given informed consent.

Staff have an allocated handover period of ½ hr to ensure that staff are fully informed regarding each patient's care and treatments. The information needed to provide quality care to the patients is very often quite comprehensive.

Specialist teams that the hospice work with visit the hospice to continue with any ongoing treatment and this specialist service also provides teaching sessions for staff as requested by the RGNs. Staff are trained in 'M' technique (hands and feet) as a means of providing relaxation and comfort to individuals; they also teach relatives this technique if a relative would like to do this. If a resident wanted to have complimentary therapy from a registered therapist, the person's GP is provided with a form to sign, to give consent for a person to be able to have/not able to have complimentary therapy, due to other treatments, medication or medical conditions etc.

STANDARD 8: HEALTH AND PERSONAL CARE

OUTCOME: Service user's health care needs are fully met.

Key findings/Evidence:

There is a selection of equipment available to help meet the moving and handling needs of both the in-patients and service users at day hospice. There are 4 trained ErgoCoaches in the team. The ErgoCoaches focus on practical skills and teaching problem solving techniques. The aim is to optimise patients' functional status and to minimise risk. The theory element and introduction to hospice manual handling equipment is undertaken at all staff inductions. Ongoing training for theory is undertaken through link days (days where ErgoCoaches are supernumerary) and all ErgoCoaches are able to do this.

There is a variety of equipment available to assist with pressure care management that can be adjusted as required in accordance with a person's weight to facilitate comfort and level of movement required. The airflow generator is also extremely quiet and patients find these mattresses very comfortable. A Pentaflex mattress is also available if needed. A lateral tilt palliative care mattress OSKA series V4 -L is also available. This mattress aids pressure relief by tilting automatically if a person is in too much discomfort to be turned regularly.

Each person has an assessment completed within 24hrs of admission, this follows prior information that has been obtained and a period of observation. A person is then re-assessed weekly, twice per week, or more frequently (every 2-3 days) if the person's condition directs this to be necessary. An accredited scoring tool (Braden score) is used to identify a person's level of risk so that the need for preventative measures can be determined before a pressure injury occurs. A RGN acts as a link nurse for tissue viability and provides feedback to the rest of the team following updates. The Tissue Viability Specialist Nurse from within HSC also provides additional support and

advice where required.

Each person's care record is indexed, which makes it easier to locate the information required. Visits from other allied healthcare professionals e.g. GPs and specialists are also filed in the individual person's notes; demonstrating that information from other professionals involved in the person's care is shared to ensure the person's needs continue to be met.

People are provided with access to other support services if required e.g. Complimentary Therapists, Bereavement Counsellors, Occupational Therapists, Dietician, Social Worker, Speech and Language Therapist and the Palliative Care Team. The Hospice Director or her deputy also have weekly meetings at Bulstrode House with the healthcare team involved with providing care for people with a terminal illness e.g. Oncology Consultant and Pharmacist etc; as previously discussed in this report. This is excellent and facilitates the delivery of effective care for people and also provides best practice updates for the hospice team.

Discussion was held with 3 people who were in-patients and their relatives. All 3 people couldn't speak highly enough of the care they receive. They described the staff as kind and compassionate and said absolutely nothing is ever too much trouble. They said staff are professional, respectful and have a good sense of humour, which is needed at times. Relatives said they are made to feel very welcome, staff are always cheerful and warm. One relative said "the support to me has been immense, for which I will always be grateful and I will remember these kind people for the rest of my life".

STANDARD 9: MEDICATION

OUTCOME: Service users where appropriate, are responsible for their own medication, and are protected by the home's policies and procedures for dealing with medicines.

Key findings/Evidence:

Medication is ordered on a weekly basis and is stored as per current guidelines and regulations. The hospice now has a Patient Group Directive (PGD) in place. The PGD allows specified health care professionals to administer a medicine directly to a patient with an identified clinical condition without the need for a prescription or an instruction from a prescriber. The health care professional working within the PGD is responsible for assessing that the patient fits the criteria set out in the PGD. This is regularly updated and training is provided every 3 years.

Controlled drugs are stored in compliance with the standards and there is a register for administration in place. Where a person has a transdermal patch applied for the administration of their medication e.g. fentanyl, a transdermal form is in place. This provides details of the time the patch was applied so that checks can be made that the patch remains in place and there are no reactions to the skin at the site of application. There is also a form for the use of a syringe driver to ensure that a person requiring a syringe driver is monitored closely, for example the dose, site of needle and person's health condition.

All medications delivered to the hospice are checked in and signed for. The hospice has access to most specialist drugs available in the UK. Staff keep themselves updated with the medication used within the Specialist Palliative Care Services, as the hospice subscribes to www.palliativedrugs.com, which provides lots of information.

Most in-patients would not want to take responsibility for their medications, as they are generally too unwell; however, if a person wanted to self medicate, a risk assessment is undertaken to ensure the person is able to do so and this would be documented in the nursing notes and would be regularly monitored. People attending the day hospice are encouraged to maintain their independence (if well enough) as they are undertaking this task at home (technique assessed and documented in care notes). Each in-patient has a medication administration record (MAR), which includes the person's name, date of birth, GP and known allergies.

There are policies for the preparation, administration and disposal of medications (returns book for medication returned to pharmacy). In between the inspection and the writing up of this report, the deputy Chief Pharmacist from within HSC undertook a medication inspection. The medication system was found to be managed efficiently; no further recommendations were made.

Implementation of a new system is currently in progress. Once installed, the system will allow GPs to print prescriptions whilst at the hospice, which will prevent a delay in the prescribing of medication.

STANDARD 10: PRIVACY AND DIGNITY

OUTCOME: Service users are treated with respect and their right to privacy is upheld.

Key findings/Evidence:

All 7 rooms are large and are en-suite, which makes it easier for the team to provide individualised care to patients in total privacy. Although there is a window in the door of each resident's room, which can be closed to 'frost over' when a resident requires privacy, an additional privacy curtain is fitted just inside the door. When the window is adjusted for staff to look in, she/he can see the curtain is pulled across to indicate that a person is being attended to, or does not want to be disturbed (also have 'do not disturb' signs to hang on door). The curtains are disposable and are dated for changing purposes to further support infection control.

There is an open visiting policy; however, the RGNs would restrict visiting either at the request of a person or if they felt the person's health would benefit from restricted visiting. This would be organised with the person (if able) and their relatives and would be documented in the person's care plan. The visitors signing in and out book requires the visitor to write down the number of the room he/she is visiting (no names); for additional privacy, which is a good initiative.

It is established on admission how a person wishes to be addressed e.g. Christian name or more

formally and this is documented in a person's care plan and all staff are informed at handover.

Generally, staff would not open a person's mail. Mail is forwarded to the person's NOK for people who are unable to manage their own affairs, however, occasionally the RGN is asked by a person to read out a letter or card, or to open an appointment letter. No person is photographed without their prior consent e.g. day hospice activities on their website.

The importance of privacy and dignity is included during induction for new staff and there are policies and procedures for maintaining privacy and dignity; including the use of social networks and for adult protection.

STANDARD 11: DEATH AND DYING

OUTCOME: Service users are assured that at the time of their death, staff will treat them and their family with care, sensitivity and respect.

Key findings/Evidence:

The hospice specialises in care and support for people who have a life limiting disease/illness and for people who require care and support at the end of their life. There is detailed assessment documentation, which provides evidence that people's needs are actioned promptly, such as pain control, symptom control, cerebral agitation, nausea and vomiting and for shortness of breath etc.

People are asked at various stages of their illness about sensitive issues, such as resuscitation or preferred place of care at the end of life. All senior HCAs have completed an NVQ/VQ unit for end of life care. HCAs have opportunity to discuss with the RGN in charge of the shift if the person is unable to follow through with the care of a dying patient. Debrief sessions are regularly available for all staff to attend to discuss or work through any issues during the admission or last hours of care for the patient.

The environment of the hospice provides privacy as all rooms are single occupancy and are en-suite. Each room has a private terrace where people can enjoy the finer weather; a person's bed can be wheeled out onto the patio if desired.

Relatives are able to stay for as long as they wish when their relative is at the end stage of their life, unless the person has indicated otherwise. The staff also provide refreshments and support for relatives, demonstrating a high level of concern and sensitivity for the relatives at this difficult time. There is a sitting room with coffee and tea making facilities and a relative would also be able to sleep at the hospice should the need arise, so they can be close to their relative (sofa beds provided in lounge or in relative's room if required).

When a person passes away, the staff continue to offer support to the person's relatives. A telephone call is made by a RGN or HCA who has completed training for this extended role, 4 weeks after bereavement. This is to assess the level of support a person requires after the funeral

has taken place.

An information pack with guidance notes and information regarding bereavement support services is offered to relatives. They are then able to utilise this when they are ready to reach out for support, or when they identify the need to do so. The Ward Manager said this could be weeks, months, or up to a year after the bereavement. The Hospice Bereavement Team will offer up to 4 sessions and discuss with the client to identify if further support is needed when these sessions come to an end. Staff provide contacts for the bereavement service and external accredited Bereavement Counsellors provide counselling for patients and for their relatives as required. The Nurse Manager and a RGN have also completed a Diploma in Bereavement Counselling, which is excellent.

The team have access to policies and procedures for end of life care and for resuscitation and there is also a defibrillator, which the RGNs and the HCAs are fully trained to use. These staff have also undertaken training for anaphylaxis.

STANDARD 12: SOCIAL CONTACTS AND ACTIVITIES

OUTCOME: Service users find the lifestyle experienced in the home matches their expectations and preferences, and satisfies their social, cultural, religious and recreational interests and needs.

Key findings/Evidence:

It is acknowledged that some people are often too ill to participate in activities and therefore the staff facilitate individual activities for these people to support choice, ability, importance and opportunities, for example; TV, radio, company to talk and to sit out in the garden, books and magazines and arts and crafts if able to do. Some people bring in their own laptop computers and mobile telephones etc.

The hospice has a chapel where services are held; or for a person or relative to visit at any time of the day or during the night. The Healing Music Trust and a pianist visit the hospice periodically throughout the year.

At previous inspections, people who attended the day hospice said that they enjoyed attending due to the social aspect where they have made good friends. They offer support to each other and are able to gain the necessary support from the care team and the team of volunteers who also support the service. The Hospice Chaplain also visits the hospice to spend time with the day hospice group each Thursday as well as visits in-between as requested by an in-patient, relative or nurse. Discussions with service-users provided good examples of the type of support individuals received, which also extended to the carers supporting the person at home. In-patients are also able to join in with the day hospice activities if they feel well enough to do so.

Activities enjoyed at the hospice are; bingo, arts and crafts, memory box, quizzes and Bridge games

etc. Exercises to music sessions are also enjoyed. Outside speakers are also arranged. There is a therapy room where patients can enjoy therapeutic treatments and relaxation and the lovely mature gardens, with a pond and fountain make for a pleasant walk/sit in peaceful surroundings.

If well enough, in-patients and day hospice service users like to help out with fundraising activities and are often involved with making cards or helping out with a raffle etc.

STANDARD 13: COMMUNITY CONTACT

OUTCOME: Service users maintain contact with family/friends/ representatives and the local community as they wish.

Key findings/Evidence:

The hospice actively encourages people to maintain contact with family and friends and there is an open visiting policy (or as advised by the RGNs) whereby relatives can stay with their relative for as long as they want to. People are able to go home for weekend leave if they are well enough and this is encouraged to facilitate quality of life and to prevent a person from losing confidence to go home while they are still able to. If a person is receiving respite care, they are encouraged to continue to attend the usual day services that they attend within the community, if they are well enough. If the person is not able to organise transport with a family member or friend etc, voluntary transport can be organised if necessary/available. If not well enough to go out, celebratory events can be organised to be held at the hospice.

As previously discussed, when a person has received in-patient care and has been discharged home, the person is able to continue to attend day hospice service for as long as the person wants to; as this has been identified as a valuable support network for the person and their family/carer.

STANDARD 14: AUTONOMY AND CHOICE

OUTCOME: Service users are helped to exercise choice and control over their lives.

Key findings/Evidence:

The management encourages people to bring in personal items to personalise their room during their stay and there is a safe in the office if a person wants to store valuables. However, generally people are encouraged to give such items of value to their NOK to take home for safekeeping.

All care is planned with the person and/or their relative's involvement and the team support a person to make informed choices regarding their care and treatment. A person is supported to follow their spiritual and religious practices as fully as possible.

If a patient requested access to their personal record this would be organised between the RGNs and the person's GP.

There are policies and procedures in place for adult protection, safekeeping of money and valuables and for guardianship orders.

STANDARD 15: MEALS AND MEALTIMES

OUTCOME: Service users receive a wholesome, appealing, balanced diet in pleasing surroundings at times convenient to them.

Key findings/Evidence:

Three full meals a day are offered and the cooked meal is provided by the catering department from within HSC using the cook-chill system, which the hospice director says continues to work very well, especially with the fluctuation in the number of in-patients on a daily basis; including when day hospice services are open. The hospice has developed a good working relationship with the catering department who are able to provide a good selection of dishes for people to choose from and is able to cater for special dietary requirements. People who require therapeutic meals or supplements are catered for and the staff assist people with their meals as necessary. There is also a selection of snacks and drinks for people to have throughout the day as due to their condition a person may not feel like anything to eat at a mealtime but may want something a bit later on. A record is maintained for each person for the meals they have chosen; portion size and how much of each meal or snack a person has eaten as a further measure for managing a person's individual nutritional needs. People are not woken up at a set time for their breakfast; breakfast is provided when they wake up and are ready to have something to eat. A person is also asked for their supper choice ½ an hour prior to supper time so this is not too far in advance, to facilitate nutritional needs and the short period of time when a person may have a fancy for a particular dish. A fridge is also available for patient's use so that a person's relatives and friends can bring the person in some of their favourite foods or drinks if they wish.

An Environmental Health Officer undertook a food hygiene inspection in July 2018 where the kitchen environment, storage of foods and hygiene of these areas was found to be of the highest standards and as a result the hospice retained their 5-star rating, which is excellent. Records are retained for receiving food orders in to the home, cooking probe temperatures, cleaning schedule and the temperatures are recorded for fridges and freezers to ensure the correct temperature range is maintained. A 'Kitchen Handbook' is also in place for all staff and volunteers and includes information such as infection control, food hygiene and dietary requirements. Staff complete food hygiene training in-house, through e-learning.

STANDARD 16: COMPLAINTS

OUTCOME: Service users and their relatives are confident that their complaints will be listened to, taken seriously and acted upon.

Key findings/Evidence:

There is a written procedure for making a complaint and this is discussed with a person when the person is admitted. The Hospice Director and her deputy are visible around the hospice each day when they are on duty and are always speaking to people; asking how they are getting on, if there is anything they need etc. Relatives are also offered a high level of support from the management and the nursing staff; therefore, complaints are very rare. This is excellent and demonstrates that the team are pro-actively managing a potential issue before it develops into a formal complaint.

There are two suggestion boxes, one in reception and one in the sitting room (The Amy J Room) where a person can make a suggestion, raise a concern or to give feedback. This can therefore be provided anonymously if preferred. The Practice Development Lead gives all patients a feedback form when a person is discharged (with a SAE). A feedback form is also included in the information booklet, which can be removed and either handed to the management or can be placed anonymously in the suggestion box. A feedback form is also available to download from the hospice website.

There is information on display for referring a complaint to the Registration and Inspection Officer from within HSC if the complaint cannot be resolved by the management of the hospice.

STANDARD 17: RIGHTS

OUTCOME: Service user's legal rights are protected.

Key findings/Evidence:

A person is able to access an advocacy service if necessary, which would generally be with involvement from the person's Palliative Care Social Worker. There is a telephone in each person's room to enable them to make private calls and some people bring in their own mobile telephones and laptops.

The staff have access to policies and procedures for adult protection, maintaining confidentiality and for data protection and the induction policies include legal responsibilities.

STANDARD 18: PROTECTION

OUTCOME: Service users are protected from abuse.

Key findings/Evidence:

There are adult protection policies in place as mentioned above and these are included in the induction programme; for example, recognising and reporting abuse, inappropriate restraint and non-involvement in a person's personal or financial affairs. Refresher training for adult protection and safeguarding children is undertaken by the team regularly, either at the Institute of Health & Social Care Studies (IHSCS), or in-house by the link person who is a senior RGN and provides

training for all HCAs and has responsibility for updating the policy.

As previously discussed in this report there is a consent form to be signed by a person and/or relative when the decision has been made to use bed rails for the person's safety or for the use of a heat pad, following a prior risk assessment, which is good practice. There are bumpers for the bed rails to protect a person from injuring him/herself and to prevent entrapment.

The people who were spoken to on the day of inspection said they felt safe at the hospice. They said that they felt comfortable to raise a concern if anything was worrying them or if they observed anything that made them feel uneasy. They were confident that they would be taken seriously and the appropriate action would be taken.

If the Hospice Director or the Nurse Manager had any concerns regarding a member of staff being unsuitable to work with vulnerable adults, they said that they would not hesitate to inform the Registration and Inspection Officer from within HSC (Hospice Director has done so previously).

STANDARD 19: PREMISES

OUTCOME: Service users live in a safe, well- maintained environment.

Key findings/Evidence:

The hospice is a purpose-built facility, which offers a safe, comfortable and spacious environment. All rooms are large, single, en-suite rooms, which have a screened private terrace. The communal rooms are pleasantly decorated and furnished and can be flexible depending on the activity that is taking place. Day hospice also has its own facilities e.g. lounge, dining area and toilets etc. There is also a Chapel which can be accessed at any time by in-patients, day hospice service users, relatives and staff.

The patient accommodation has been well planned so that all of the accommodation and communal areas for patients and relatives are on the ground floor. Offices and staff changing rooms are situated upstairs, with a separate entrance so that patient privacy is maintained and for additional security (swipe cards) within the building.

All flooring and furnishings were purchased following consultation with the Infection Control Specialist Nurse from within HSC and the latest guidelines for this type of establishment. The team continue to work hard to make the hospice as 'homely' as possible.

STANDARD 20: SHARED FACILITIES

OUTCOME. Service users have access to safe and comfortable indoor and outdoor communal facilities.

Key findings/Evidence:

Patients are permitted to smoke outside only (signage in place) and there is a smoking and vaping policy in place. Relatives are not permitted to smoke in the hospice grounds. Information is available in the hospice booklet and also on the hospice website. The Palliative Care Specialist Nurses and GPs are asked to discuss this with people prior to admission. This is to enable people to make an informed decision regarding admission and how this will affect them when they are smoking.

The hospice building provides a comfortable, light and airy environment. The furniture, fittings and equipment have been purchased to encourage comfort and ease of use. Also to meet the latest guidelines and recommendations for environmental safety, fire safety and for infection control. The communal areas are very spacious and have flexibility to adapt for various activities that may take place throughout the year and there is a lovely Chapel where services are held.

The gardens are mature and are kept well maintained with a variety of colourful and therapeutic flowers and shrubs. There is good access for people with varying degrees of mobility and there are several areas for seating. The pond and fountain provide a very calming atmosphere, as the garden is very peaceful with a lovely sound of running water.

STANDARD 21: LAVATORIES AND WASHING FACILITIES

OUTCOME: Service users have sufficient and suitable lavatories and washing facilities.

Key findings/Evidence:

All rooms are en-suite so people have their own washing and toilet facilities. Grab rails have been fitted appropriately throughout. There are also communal toilets situated throughout the building along with separate facilities for visitors and staff. There are 4 assisted bathrooms with an excellent amount of space for the use of large pieces of equipment such as a hoist or wheelchair and all of these facilities have a call bell.

STANDARD 22: ADAPTATIONS AND EQUIPMENT

OUTCOME: Service users have the specialist equipment they require to maximise independence.

Key findings/ Evidence:

The hospice has a wide range of equipment available for patients; demonstrating the hospice's commitment to ensuring that a person's care needs are being met and manual handling issues addressed. The equipment includes adapted cutlery and crockery for a person to maintain as much independence as possible with managing their meals, airwave mattresses, pressure relieving cushions, profiling beds, oxygen administration, nebuliser, suction machine, syringe drivers, sliding sheets for each room, raised toilet seats and hoisting equipment. Each room has a hoist, which is able to transfer a person from their bed into the bathroom. This is excellent as it enables a person

to use their own en-suite for as long as possible to maintain their privacy and dignity rather than having to use a portable facility by the bedside.

STANDARD 23: INDIVIDUAL ACCOMMODATION: SPACE REQUIREMENTS

OUTCOME: Service users' own rooms suit their needs.

Key findings/Evidence:

All rooms are spacious and have plenty of room to accommodate a profile bed with adequate space for staff to move around the bed with ease when providing care or using the hoist or other pieces of large equipment. There is also a comfortable electrically operated reclining chair (risk assessed prior to use), television, chairs for visitors and a bedside cabinet and bedside table. The room is very bright with natural light and every room has its own terrace outside of the double patio doors. Each terrace is screened to provide additional privacy. There is also a privacy curtain as you walk in to each room as the doors have a window where a member of staff can check on a person so that the person is not disturbed by someone opening the door. The privacy curtain is pulled across for additional privacy or if the person is receiving attention.

STANDARD 24: FURNITURE AND FITTINGS

OUTCOME: Service users live in safe, comfortable bedrooms with their own possessions around them.

Key findings/Evidence:

People are able to personalise their room if they wish and are encouraged to do so. People are not admitted into the hospice for long-term care but are welcome to bring in some of their smaller chosen personal possessions for the duration of their stay e.g. photographs.

A television is provided and people also have access to a telephone; some people bring in their own mobile telephone or laptop. All rooms have Wi-Fi.

Bed linen and towels are changed as required; sometimes several times a day if needed.

STANDARD 25: SERVICES: HEATING AND LIGHTING

OUTCOME: Service users live in safe, comfortable surroundings.

Key findings/Evidence:

The taps in areas where people have access have been fitted with a temperature regulator to ensure the temperature of the water does not exceed the recommended maximum of 43°C to

prevent scalds from excessively hot water. Heating throughout the hospice is under floor heating. There is adequate lighting throughout the building that can be altered for various activities at different times of the day and during the evening and there is emergency lighting throughout the home.

STANDARD 26: HYGIENE & CONTROL OF INFECTION

OUTCOME: The home is clean, pleasant and hygienic.

Key findings/Evidence:

The Housekeeping Assistants are to be commended for keeping the environment clean, pleasant and odour-free. There is a sluice facility and all clinical waste is stored outside in a locked receptacle until it is collected each week for disposal. An accredited company undertakes Legionella monitoring.

The Infection Control Specialist Nurse from within HSC undertook an infection control audit in November 2018 and a score of 99% was achieved; demonstrating the staff have a clear understanding of infection control within a hospice environment. The Nurse Manager and a HCA act as link staff and have periodic update sessions with the Infection Control Specialist Nurse, which they communicate back to all of the team. Following this inspection, the team at the hospice are trialling a different system of auditing for infection control, which is supported by the Infection Control Specialist Nurse from HSC. The Infection Control Link Nurses are undertaking quarterly audits instead of the current annual audit.

The hospice has a staff changing and shower facilities and uniforms are laundered at the hospice, which is excellent practice for infection control. There are policies and procedures in place for the safe handling of clinical waste, dealing with spillages, hand washing and the wearing of protective clothing (gloves and aprons etc). A copy of HSC's infection control guidelines are also available.

Infection control forms part of the induction programme and all new staff have an hour session with the Practice Development Lead to discuss the chain of infection, use of personal protective clothing and effective hand washing technique. Staff then undertake regular refresher sessions to ensure they are up-to-date with the latest guidelines for infection control throughout their employment at the hospice.

STANDARD 27: STAFF COMPLEMENT

OUTCOME: Service user's needs are met by the numbers and skill mix of staff.

Key findings/Evidence:

From examining the off-duty for a 4-week period, the staffing numbers and skill mix for the number of in-patients and their dependencies are good. If the hospice is at full capacity, or if the

dependency is high for the number of in-patients, the staffing level is as follows; Hospice Director (RGN) (supernumerary Mon-Fri from 8am-4pm), 1 or 2 RGNs on duty in the morning from Mon-Fri (1 at the weekend, although is increased to 2 if needed) with 2 or 3 HCAs (at least 1 senior HCA. During the afternoon and evening there is 1 RGN with between 1-3 HCAs (1 additional HCA for 5-11pm twilight shift when needed - occasionally) and at night there is 1 RGN and 1 HCA. The staff level fluctuates from week to week depending on the number of in-patients, which can range from 0-7 (6 on the day of inspection). Also taken in to account is the dependency level for each person and the management of each person's medication as some medication regimes can be quite complex. Additional staff are also needed when day hospice is being provided, if there is a student nurse on placement who would require supervision and also if training is taking place.

Dependency levels are monitored from shift to shift and the staffing level is adjusted accordingly as admissions could be 1-2 in a single day. Due to this factor, workforce planning is undertaken one day for the following day where adjustments can be made to the existing rota as needed. If more people are admitted, it is indicated on the off-duty who is available to come on duty at short notice (established and bank staff).

The RGNs and HCAs are also supported by a team of Housekeeping Assistants and Administrative Team, as well as the much-valued support from volunteers who undertake various roles within the team from the day-to-day involvement with the operation of the services and development of the activity programmes, to the organisation of fundraising. Outside contractors provide services for gardening and for maintenance work and for servicing of equipment and appliances.

STANDARD 28: QUALIFICATIONS

OUTCOME: Service users are in safe hands at all times.

Key findings/Evidence:

The hospice has RGNs who lead the team of HCAs. The Nurse Manager has a Diploma in Adult Nursing, Midwifery and Psychiatry and also has a Diploma for Bereavement Counselling and provides sessions for relatives. Three RGNs (1 bank RGN) and 2 HCAs have completed training for Bereavement Counselling and are part of the Bereavement Team.

The Practice Development Lead has a Masters Degree for Palliative Care and also a Diploma in Adult Nursing. She also undertakes responsibility for staff training and has also completed the VQ assessor award. One RGN has a Degree in Healthcare Practice. Two RGNs have a Diploma in Higher Education in Adult Nursing. One RGN has an Advanced Diploma in Adult Nursing. One RGN has a Bachelor of Nursing (hons). Four HCAs have a VQ award at level 3 and 1 HCA is currently undertaking the Associate Practitioner course.

Assessor training is also undertaken by the RGNs to enable student placements through the IHSCS from within HSC. A qualified assessor is required for each student for supervision, throughout their placement. There are currently 4 assessors within the team.

STANDARD 29: RECRUITMENT
OUTCOME: Service users are protected by the home's recruitment policy and practices.
Key findings/Evidence:
<p>There is a robust recruitment procedure in place. All new employees have a police check; enhanced for RGNs and HCAs and a basic check for all other staff who are not involved with assisting with personal care. Three written references are required and an interview is undertaken before an applicant is confirmed in post. The Volunteer Co-ordinator has the responsibility for managing this process for the volunteers who work at the hospice.</p> <p>The RGNs are required to be on the NMC register and are required to revalidate to demonstrate that they continue to be a safe practitioner, in order to protect the public. All of the staff records are kept locked away in the office and the Hospice Director, Nurse Manager and the Office Manager are the only people who have access to this information.</p> <p>In the event of employing staff from abroad, the Hospice Director is aware that a police check must be sought from the country of origin either by the agency from which the person is recruited, or from the individual, as local Police checks are only available to those working locally or from the UK.</p> <p>All staff have access to policies and procedures for health and safety, fire and emergencies, confidentiality and data protection, whistle-blowing, receiving of gifts and wills and for adult protection. Guidelines are also available for the process followed by HSC.</p>

STANDARD 30: STAFF TRAINING
OUTCOME: Staff are trained and competent to do their jobs.
Key findings/Evidence:
<p>New staff undertake induction on appointment and there are different induction packs for the various roles and responsibilities e.g. HCAs, bank HCAs, RGNs, bank RGNs (more specific pack for RGNs at bands 5 and 6) and for volunteers etc. The induction pack sets out conditions of service. It is then a practical guide to all that the new employee needs to know to be able to work effectively. The pack covers all of the policies the person needs to be familiar with and all of the equipment the person will need to use. Included in the information are informative website addresses to promote further study. The formal induction programme consists of at least one day for HCAs and three days for RGNs. These are taught days, provided by the Practice Development Lead and focus on areas such as infection control, fire safety, PGD training, medications and the use of a syringe driver.</p>

When the induction programme has been completed, the documentation that is relevant to the person's role within the team, i.e. medication management, witnessing controlled drugs and confidentiality etc is then signed off by the Practice Development Lead.

On completion of the induction, the employee is given a questionnaire to complete and this includes a section to rate him/herself, which is a good initiative. This provides valuable information in relation to how effective the induction has been and enables the employee to give feedback and to make suggestions for ongoing development of future induction sessions. New staff are supernumerary for a minimum of 2 weeks; this is extended if the Hospice Director or the Nurse Manager thought this were necessary. Volunteers also receive an induction; the length of the induction period depends on the role the person is undertaking within the team.

Following induction, a new employee has a programme of training, which is built upon throughout their employment at the hospice and the Practice Development Lead manages a spreadsheet of all training provided (90% achieved for completion of mandatory training). Mandatory training such as first aid and resuscitation (including AED), infection control, moving and handling (4 Ergo coaches in the team), fire safety and safeguard training (including child protection) are updated as advised by the accredited trainer. Additionally, staff undertake training for food hygiene, conflict resolution, COSHH and anaphylaxis. As discussed in standard 28, four HCAs have a NVQ award at level 3; with 1 HCA currently undertaking the Associate Practitioner course (almost completed 1st year).

The RGNs have individually undertaken training in various subjects to ensure good-all-round knowledge within the team, for example, updates for palliative care, anaphylaxis, venepuncture, catheterisation, diabetes, dementia care, wound management, breakaway training, safeguarding (adults & children), bereavement counselling, managing difficult conversations (Sage & Thyme foundation level – continuing to develop to a higher level), assessor training (4 assessors for student nurse placements) and advanced pain management and symptom control.

Bank staff are also supported through an induction and if they have not worked in the hospice for a 3-month period, are required to undertake a repeat induction before taking charge or working another shift. This is to ensure that they are still up-to-date with the hospice practices and procedures, again this is exemplary. The hospice also provides training for staff off-island at hospices in the UK who have specialist hospice care facilities. Three RGNs are due to undertake this course this year following a 6-12 month period of working at the hospice. This ensures that the hospice is up-to-date with changes in practice for providing care and support to their client group.

There is a monthly debriefing meeting for staff to discuss issues of concern and training is in place to develop staff awareness and to assess their capacity for spiritual care.

A staff resource room is also available, which includes computers for study, research and e-learning training and a selection of books and journals, which are relevant to practice.

STANDARD 31: STAFF SUPERVISION**OUTCOME: Staff are appropriately supervised.****Key findings/Evidence:**

Various staff meetings are held to facilitate good levels of communication in the team. There is a staff meeting, which is held every month (RGNs one month & all staff following month). The meetings are minuted and are displayed on the staff notice board. This is important as this avoids situations when staff claim not to have been informed of various issues. The minutes include items such as results of audits, practice issues, and changes to practice etc. Meetings are also held for debriefing staff, RGN only meetings to discuss medications, practice development and quality assurance (meeting includes Hospice Director, Ward Sister, Ward Manager and Senior HCA).

When a new member of staff joins the team, the person has a programme of induction. The Care Certificate forms part of the induction package which is now in place for all HCAs. The HCAs have 2 weeks of formal induction and then they continue to work through the programme over a 6-month period. A reflection form forms part of the induction pack. This can be completed by the employee, as needed, which then enables areas to be identified where additional supervision is required, or where practice could be further developed operationally.

A staff appraisal system is in place. An initial review following induction is followed up by a 6-month progression review. This is then followed on by an annual review to identify training needs that have been identified between the employee, Nurse Manager and the Practice Development Lead, which are then actioned. The Nurse Manager, Ward Sister and the Practice Development Lead work alongside and supervise staff on the floor each day; thus demonstrating staff are adequately supervised. Some of the senior RGNs also have a clinical supervision session 8-weekly with a person from outside of the hospice team.

The hospice employs a Volunteer and Retail Manager who applies the same rigorous recruitment procedures as those within the hospice's permanent staff (as previously discussed). The type of role they have volunteered for dictates the content of their induction and supervision. Volunteers working in the kitchen or delivering teas etc, receive food hygiene/handling training.

The hospice has also been accredited for student placements through the Institute of Health and Social Care Studies (IHSCS). They offer placements for 1st, 2nd and 3rd year students, who have an assessor for the duration of their placement. A trainee Associate Practitioner is currently on the 3rd week of a 4 week placement. An education audit is undertaken every 2 years to enable the hospice to maintain their accreditation and the feedback from the students continues to be very positive.

STANDARD 32 MANAGEMENT AND ADMINISTRATION**OUTCOME: Service users live in a home which is run and managed by a person who is fit to be in charge, of good character and able to discharge his/her responsibilities fully.**

<p>Key findings/Evidence:</p> <p>The Hospice Director is very experienced in hospice care, she is a RGN and was a Director of Nursing at Pilgrims Hospices; a group of hospices in Kent, for 15 years. She also has an ENB 998 (certificate in teaching and assessment) and a certificate in management. She has worked in this senior position at the hospice in Guernsey for 13 years and is supernumerary in her role. This enables her to be visible around the building; regularly walking around to talk to all of the in-patients and their relatives and to the service users of the day hospice. This is to ensure people are receiving the care/support they need and are satisfied with the service. She is very approachable in her manner and always seems to have an eye on who is coming in and going out of the hospice. She is aware of the accountability that her position holds and is regularly on-call out of hours. Both the Hospice Director and the Nurse Manager take it in turns to be on call. If there are any difficulties at the hospice, the RGN in charge contacts the person on call and she would come in to the hospice to speak to a patient or their relatives if needed.</p> <p>The Hospice Director attends updates for mandatory training, child protection, adult safeguarding and also in many areas for palliative care – managing difficult conversations, managing the impossible, and advanced symptom control etc. Also for her management role – preparation for revalidation (RGNs), team building and understanding people, and for performance management for staff.</p>

<p>STANDARD 33: MANAGEMENT AND ADMINISTRATION: ETHOS</p>
<p>OUTCOME: Service users benefit from the ethos, leadership and management approach of the home.</p>
<p>Key findings/Evidence:</p> <p>On the day of inspection there were 6 in-patients; day hospice was not open (currently Thursdays only). As previously discussed in this report 3 people who were spoken to who were in-patients and 1 person pre-inspection who attends the weekly day hospice had only positive feedback to give – see also standard 8. Feedback from relatives of former patients, medical professionals and students on placements continue to suggest the hospice provides an excellent service for the people of Guernsey and a quality learning environment.</p> <p>Observation of staff interactions with people and their relatives during the day of inspection were very positive. Staff appeared relaxed and cheerful as they went about their work and people were always pleased to see them. Staff spent time with people without being rushed and conversations between staff provided evidence that people are listened to and their choices, preferences and routines are upheld wherever possible.</p> <p>Within the hospice team individual staff have areas of responsibility where they have undertaken additional training and are able to provide guidance for the rest of the staff; for example, link roles for moving and handling (Ergo coaches x 4 in the team), infection control, continence</p>

management, wound management and for health & safety etc. A senior HCA has responsibility for the management of the weekly day hospice (supported by the RGNs as needed).

The team do a lot of work with families and have previously attended training for supporting families with young children.

STANDARD 34: QUALITY ASSURANCE

OUTCOME: The home is run in the best interest of service users.

Key findings/Evidence:

There are 2 suggestion boxes for quality assurance monitoring to seek the views of service users and to measure if the aims and objectives of the in-patient service and care delivery are being met. There is also a feedback questionnaire in the residents' booklet, as previously discussed in this report. The day prior to a person's discharge a questionnaire is provided with a pre-paid envelope for a person to send in feedback once they return home if they wish. A quarterly patient & family/carer feedback report is produced by the Ward Sister and Clinical Governance Facilitator to enable the team to further develop practice and improve services where needed.

The Hospice Director and the Nurse Manager speak to all of the in-patients each day regarding the food and their care etc; recognising that it is important that service users' views are sought. The team have also received a number of cards and letters of thanks from patients and their relatives.

A Clinical Governance Facilitator monitors quality assurance and the policies that are developed for the hospice are ratified by her prior to becoming operational. Audits are undertaken for recordkeeping (MAR, care plan – individual elements e.g. nutrition), accidents/incidents, referrals and admissions, effective discharge and for environmental safety. Feedback is communicated to the relevant person e.g. hospice team, GP, Pharmacist etc. Governance meetings are held for the team involved with the provision of peoples' care. The Ward Manager said there is good attendance from the multi-disciplinary team; including from medical staff.

Risk monitoring is a high priority. As well as risk assessment for care elements, risk assessment is also undertaken for other areas e.g. COSHH.

The discharge process has several measurable components and is crucial to the successful continuity of care in the community (adequacy of discharge plans), involvement of family in discharge planning, co-ordination of care, time of discharge and notification of services (GP, Community Nurses, Palliative Care Nurses, Meals on Wheels, etc). The Nurse Manager, Ward Sister and the Practice Development Lead also continue to contribute to the audit process for the ongoing monitoring of standards e.g. communication and recordkeeping etc.

The day hospice continues to provide an invaluable network of support and information for the people who use this service. Day hospice continues to provide a service only on a Thursday due to

a current decline in demand. An increase for an additional day will be re-introduced once again, if demand for the service directs this. Day hospice is extremely beneficial for the team to identify where support is required on an individual basis e.g. symptom control, social or family support etc. The day service is reviewed regularly to ensure it continues to meet the current needs of the service users and also to 'future-proof' the service.

STANDARD 35: FINANCIAL PROCEDURES

OUTCOME: Service users are safeguarded by the accounting and financial procedures of the home.

Key findings/Evidence:

Standard not examined. The hospice is a charitable organisation and does not receive a grant from Employment & Social Security. The hospice shop income contributes towards the running of the hospice and the volunteers for the shop are recruited through the home's rigorous recruitment procedures. The hospice has a Board of Trustees, who the Hospice Director has regular meetings with to discuss the on-going operation of the hospice and financial status. The accounts of the hospice are audited annually by an independent auditor.

STANDARD 36: SERVICE USERS MONEY

OUTCOME: Service user's financial interests are safeguarded.

Key findings/Evidence:

People are cared for in the hospice for a relatively short period of time and therefore either the person him/herself if they are well enough, or their NOK, usually manage their financial responsibilities. If a person has nobody who is able to do this for him/her, a Social Worker is contacted to support the person with this.

If a person does not want to give their valuables/money to a relative for safekeeping, they can be kept in a safe in the office and a record is kept of this.

STANDARD 37: RECORD KEEPING

OUTCOME: Service user's rights and best interests are safeguarded by the home's record keeping policies and procedures.

Key findings/Evidence:

A signature list is retained for all staff who work in the home. At the front of all of the care plans is an index, which enables clear navigation through the care record. Care records that were observed

and discussed with the Nurse Manager contained comprehensive information for the care the person receives, which was holistic to include medical, psychological and spiritual needs. On each shift all care that has been given to each person is recorded and each entry is dated and signed. The people that were spoken to (both in-patients and their NOK) said they are kept fully informed of any changes with their care and consent is always obtained prior to any changes being made.

The RGNs' feedback information from their training sessions, which are used to update policies and procedures at regular intervals. The Ward Sister who has responsibility for clinical governance, is the link person for quality assurance and provides support and guidance through a program of auditing to maintain quality recordkeeping. She audits aspects of care and practice and provides feedback to the Hospice Director, Nurse Manager and Practice Development Lead so that changes can be implemented as necessary to further develop the service and the team. Further training sessions are then undertaken with the rest of the staff where areas for further development have been identified.

STANDARD 38 SAFE WORKING PRACTICES

OUTCOME: The health, safety and welfare of service users and staff are promoted and protected.

Key findings/Evidence:

The team offer good quality induction, training and ongoing supervision throughout a person's employment at the hospice to ensure all staff have the necessary knowledge and skills for the position they hold within the team. This includes for complex medication management, which the RGNs undertake.

There is a designated health & safety link. A monthly health & safety audit is undertaken and is documented and the necessary action is taken to resolved identified issues. There is a link first aider in the team who provides or organises annual refresher training for all staff. A first aid box is available at identified areas throughout the home; main kitchen and treatment room and these are checked and are replenished regularly.

Accident/incident forms are in place and a record of the accident/incident is filed in the individual person's care record. All accidents/incidents are discussed within the team (also discussed with the Board of Trustees if necessary). Following an accident/incident a risk assessment is carried out and the necessary action is taken e.g. review of care plan or policy and procedure or replacement of equipment etc. The Hospice Director and the patient's GP (where relevant) sign a filed document to acknowledge that they have been informed and can then be involved with any changes/actions that are required.

The Ward Sister with responsibility for clinical governance undertakes an audit of incidents/accidents in the home. Information viewed provided good evidence of how accidents/incidents are audited monthly and key performance indicators are used to highlight level

of risk in the categories audited. A quarterly report is developed to communicate the findings to the team so that the necessary action can be taken to resolve the issues. The Hospice Director and the RGNs are aware that they must report an accident/incident to the Registration & Inspection Officer where a person is transferred to hospital for treatment and also to report under RIDDOR where a serious injury has occurred.

There is a program in place for regular checks and maintenance of equipment (list provided). The hospice building meets all current guidelines for health and safety, environmental health and for infection control. Control of substances hazardous to health (COSHH) is undertaken and are recorded. There is a programme in place for the monitoring of Legionella.

Policies and procedures are reviewed and updated annually unless practice guidance or feedback from audits directs this to be undertaken sooner.

The entry system into the home is a swipe card entry system (for staff) to facilitate easier operation in maintaining safety and during office hours there is a receptionist at the main front door. The fire alarm is tested each week and a log is maintained.

Registration and Inspection Officer's comments

Les Bourg's Hospice provides care for people with a life limiting illness in a peaceful and supportive environment. Care is provided in a caring and meaningful way and the staff know the care needs of the people who use the service well. Staff gain consent prior to supporting people with their care and also support them to make decisions about aspects of their life that affect the person and their family.

Staff work closely with the multidisciplinary team to ensure care needs are met and care plans are detailed to enable the staff to carry out the person's wishes and to provide maximum comfort for people.

There is a robust recruitment process in place and staff are knowledgeable in relation to protecting people from harm. There is a good programme of training, supervision and appraisal to equip staff with the knowledge and skills they require to provide quality care for their client group and the staffing levels are good for the care provided.

There are governance systems in place to assess the quality of the service delivered and there is an open culture where patients, relatives, staff and healthcare professionals who visit the home are encouraged to offer their views and provide feedback.

People spoken to on the day of inspection (in-patients and relatives) spoke very highly of the hospice staff, care and support they received and the environment of the hospice; with 2 people describing it as a “first class service”.

Vanessa Penney
Registration and Inspection Officer

REGISTERED PERSON'S AGREEMENT

Registered person(s) comments/confirmation relating to the content and accuracy of the report for the above inspection.

I would welcome comments on the content of this report relating to the inspection conducted on **17/07/19** and any factual inaccuracies:

Registered Person's statement of agreement/comments: Please complete the relevant section that applies.

I _____ of _____ confirm that the contents of this report are a fair and accurate representation of the facts relating to the inspection conducted on the above date(s) and that I agree with the requirements made and will seek to comply with these.

Or

I _____ of _____ am unable to confirm that the contents of this report are a fair and accurate representation of the facts relating to the inspection conducted on the above date(s) for the following reasons:

Signed:

Designation:

Date:

Note:

In instances where there is a profound difference of view between the Inspector and the registered person both views will be reported. Please attach any extra pages, as applicable.

July 2019

